

# Hospital Presumptive Eligibility 5

## 1. HPE2013-take 3

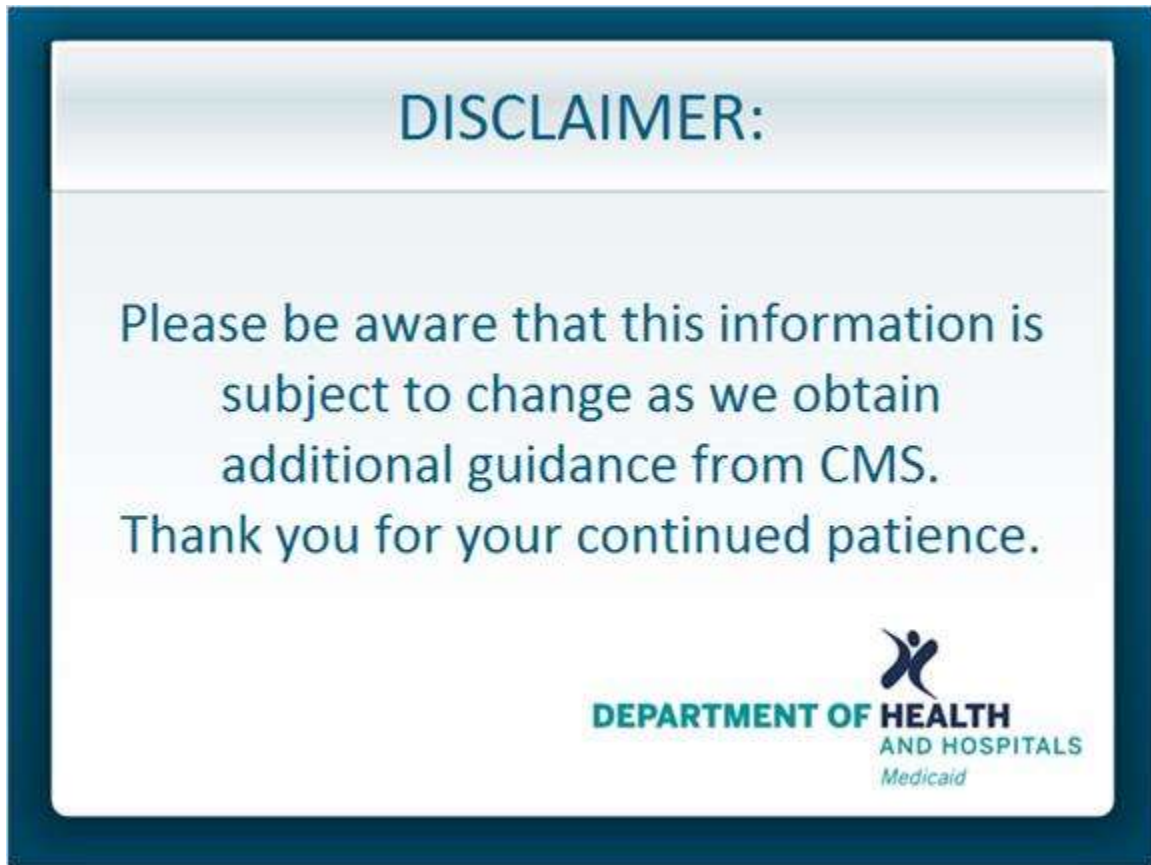
### 1.1 Hospital Presumptive Eligibility



#### Notes:

Welcome to Hospital Presumptive Eligibility training. This video will review Administrative Procedures, the HPE Assessment Process and the Medicaid Income Guidelines. Please click the topic for further details.

## **1.2 DISCLAIMER:**



### **Notes:**

Please be aware that this information is subject to change as we obtain additional guidance from CMS.  
Thank you for your continued patience.

### **1.3 DISCLAIMER:**

Please press F11 on your keyboard for optimal viewing.  
Upon completion of the course, email your certificate to [hpe@la.gov](mailto:hpe@la.gov)



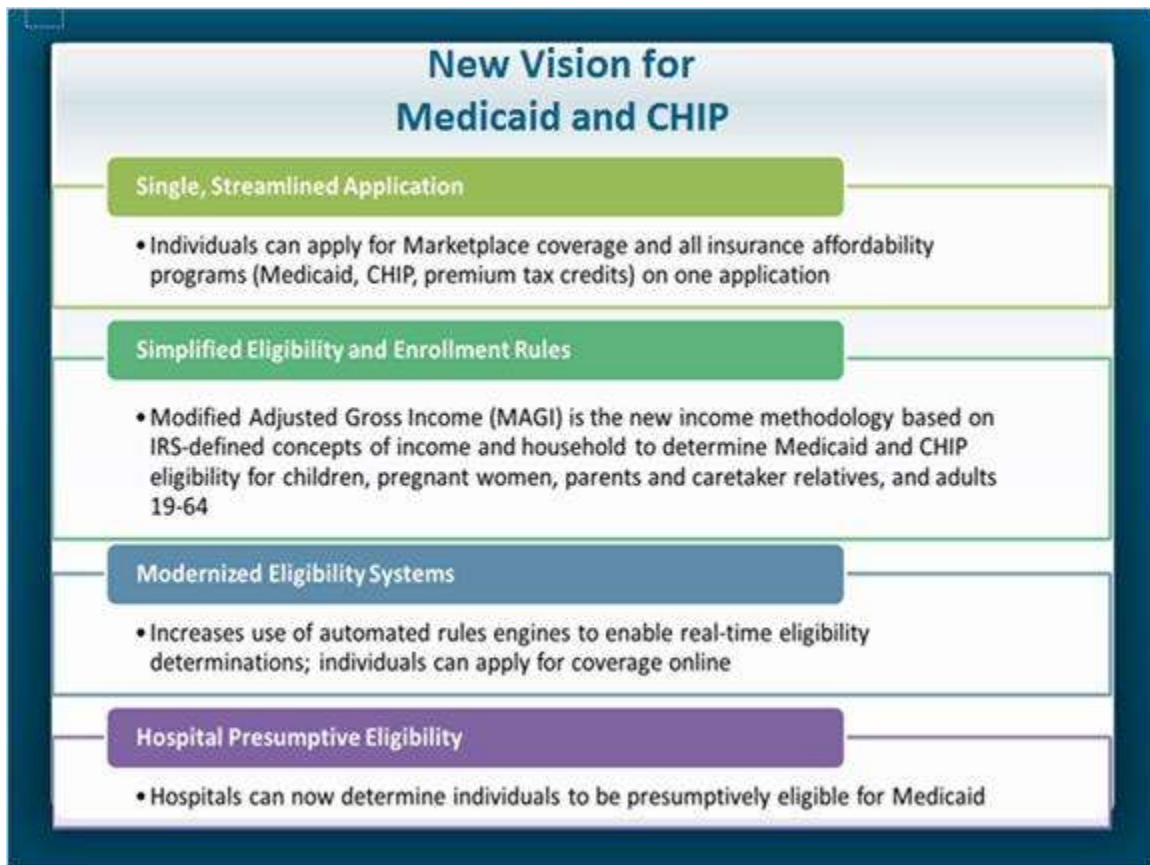
## 1.4 ACA Coverage Changes



- The Affordable Care Act (ACA) was signed into law in March 2010; it makes major changes to how people secure health coverage in the U.S. Coverage changes include:
  - Medicaid and CHIP expansion and improvements
  - Health insurance marketplaces for individuals and small businesses
  - Private insurance market reforms

### ACA Coverage Changes

## 1.5 The New Vision for



## 1.6 Untitled Slide



## ***1.7 What Is Hospital Presumptive***

### **What Is Hospital Presumptive Eligibility (HPE)?**

- As of January 1, 2014, hospitals can immediately determine Medicaid eligibility for certain individuals who are likely to be eligible
- Eligibility under HPE is temporary but allows immediate access to coverage for eligible individuals; this is discussed in more detail later in the presentation



## ***1.8 How HPE Works to Get People Connected to Coverage and Care***

### **How HPE Works to Get People Connected to Coverage and Care**

- HPE improves individuals' access to Medicaid and necessary services by providing another channel to apply for coverage
- It ensures the hospital will be reimbursed for services provided, just as if the individual was enrolled in standard Medicaid
- HPE is not about short-term coverage; it provides individuals with an opportunity to get connected to longer-term coverage options



## ***1.9 How Hospitals Can Participate in HPE***

# **How Hospitals Can Participate in HPE**



### ***1.10 How Hospitals Can Participate in HPE***

## **How Hospitals Can Participate in HPE**

- Hospital participation in HPE is optional, but states must provide a mechanism for a hospital to become qualified to conduct HPE
- To make HPE determinations, a hospital must:
  - Participate in the Medicaid program.
  - Notify the state of its election to make HPE determinations by emailing the required documents to [HPE@LA.gov](mailto:HPE@LA.gov)
    - Qualified Entity Application for Hospital Presumptive Eligibility
    - HPEQE Responsibilities and Agreement
  - Agree to make HPE determinations consistent with policies and procedures of the state. This agreement will be implied by submission of the above documents.

#### **Notes:**

Click the resources tab at the top left to view the forms.

### ***1.11 Hospital Staff Eligible to***

#### **Hospital Staff Eligible to Make HPE Determinations**

- Once a hospital is a qualified entity:
  - Any hospital employee who is properly trained and certified can make HPE determinations
    - This includes employees in hospital-owned physician practices or clinics, including those in off-site locations
  - Participating hospitals may not delegate HPE determinations to non-hospital staff
    - Third party vendors or contractors may not make HPE determinations

## ***1.12 Staff Training and Certification***

### **Staff Training and Certification**



- HPE Training (LMS)
- Affordable Care Act Training (LMS)
- Click the “Resources” tab for additional documents
- Future training will be presented via the Learning Management System (LMS)

### ***1.13 HPE Performance Standards***

## **HPE Performance Standards**

- The state has the authority to take corrective action against hospitals, including termination from the HPE program, if the hospital does not follow state policies or does not meet established standards.

STANDARDS

### 1.14 HPE Performance Standards

HPE Performance Standards	
PERFORMANCE INDICATOR	BENCHMARK
Assist HPE individuals with filing a BHSF Form 1-A for full Medicaid benefits.	70 %
HPE determination also results in HPE individual's eligibility for full Medicaid benefits.	85 %
Verify that HPE individuals have not received HPE coverage within the past 12 months.	85 %
Verify that HPE individuals are not currently enrolled in Medicaid.	95 %

#### Notes:

Louisiana Medicaid will monitor the following information on a monthly basis:

the number of monthly HPE certifications;  
the number of HPE individuals who actually complete a BHSF Form 1-A for full Medicaid benefits;  
the number of HPE individuals who were denied full Medicaid benefits; and  
the number of HPE individuals who were approved for full Medicaid benefits.

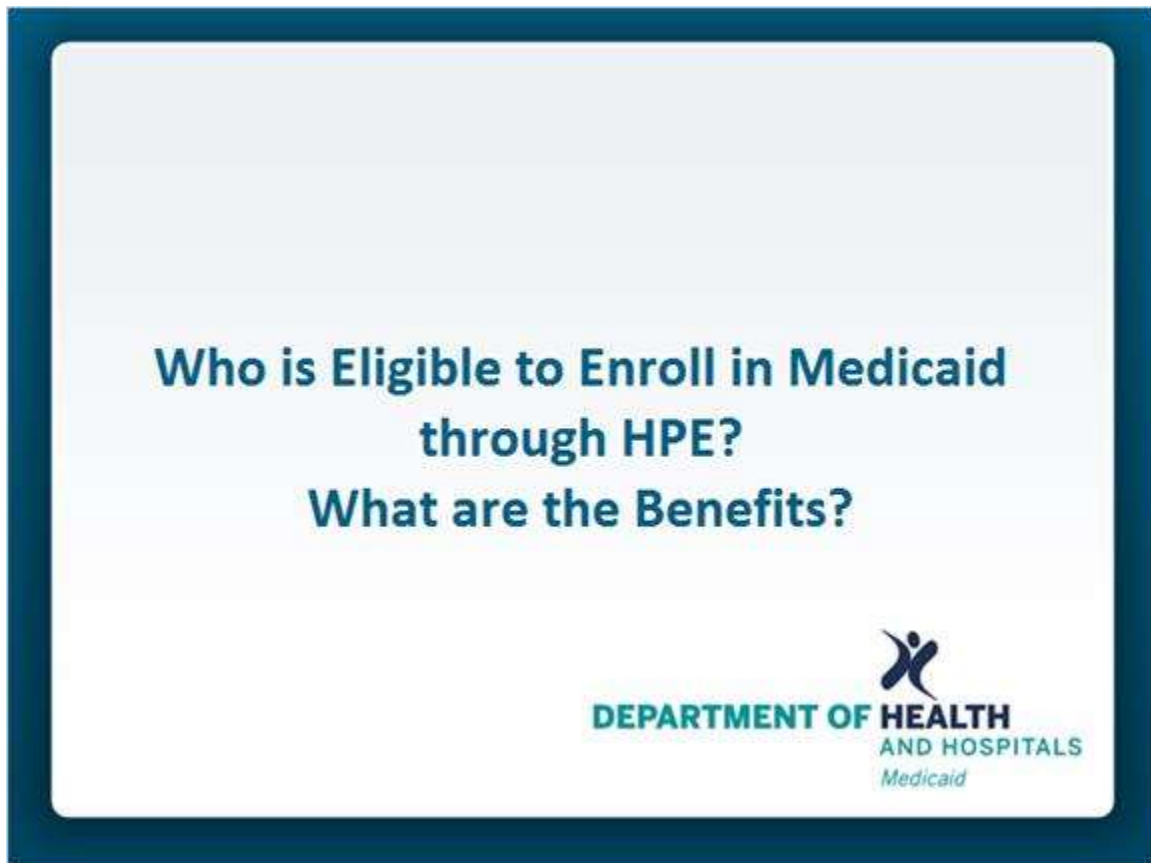
Louisiana Medicaid will monitor HPEQE performance to ensure that HPE determinations are made in accordance with state and federal requirements and meet required performance standards, as outlined in the standards for participation.

The HPEQE agrees to periodic monitoring by state officials or their designees without prior notice and agrees that state officials or their designees will have access to the premises to inspect records and evaluate work being performed.

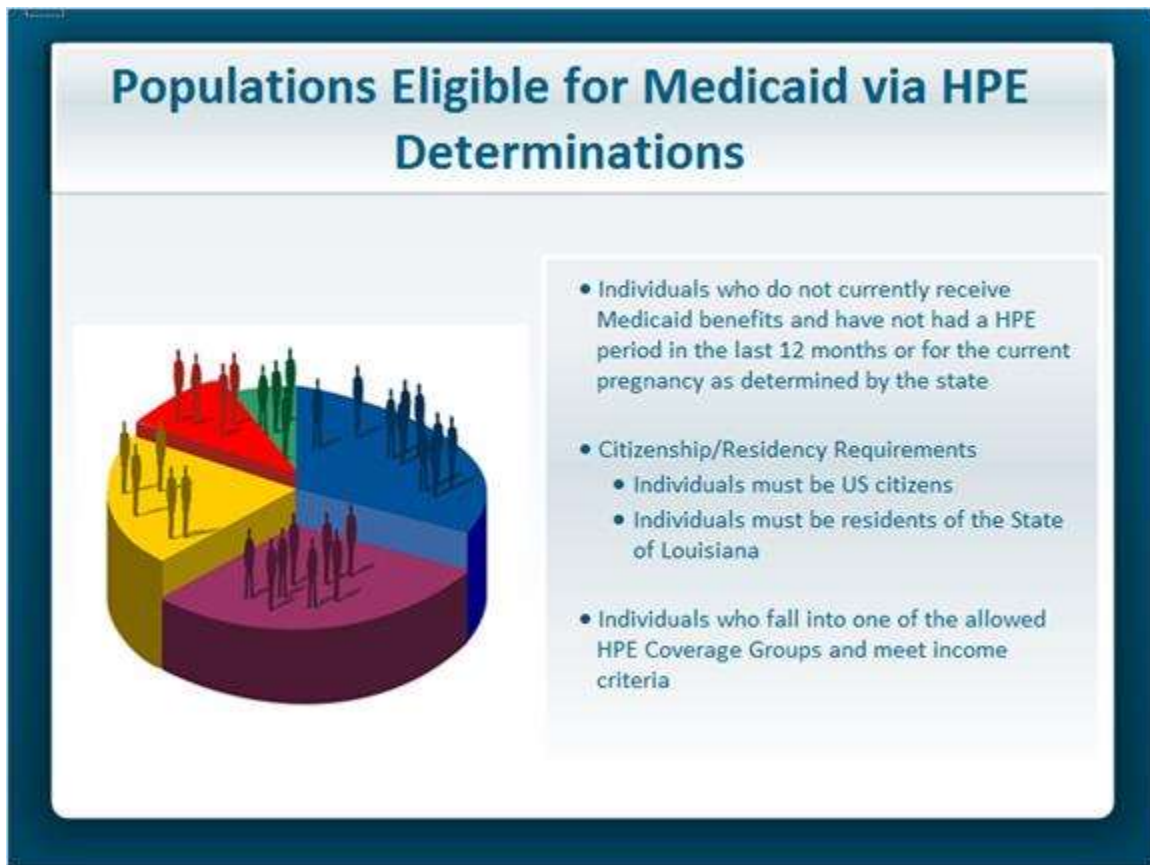
DHH reserves the right to institute a thirty (30) day period of corrective action to allow the HPEQE to address any deficiencies identified during routine monitoring, and/or as a result of failure to meet performance benchmarks, and/or for failure to adhere to the

policies and procedures of the Louisiana Medicaid HPE program.

### ***1.15 Who is Eligible to Enroll in Medicaid through HPE?***



## 1.16 Populations Eligible for Medicaid via HPE Determinations



### ***1.17 Populations Eligible for HPE***

The infographic is titled "HPE Coverage Groups" in a large, bold, blue font at the bottom. It is divided into three sections, each with a colored header bar and a list of criteria:

- Children** (purple header):
  - Under the age of 19
- Pregnant Women** (blue header):
  - Limited to ambulatory prenatal care for pregnant women
  - Limited to 1 HPE period per pregnancy
  - Coverage for certain pregnant women who are not otherwise eligible for Medicaid
    - Must be a US Citizen or Qualified Alien
    - Women with income above 133%
- Parents/Caretaker Relatives** (teal header):
  - Parents or caretakers with dependent children under 19
  - Meet certain income and eligibility requirements as determined by AFDC policy effective July 16, 1996

### ***1.18 Populations Eligible for HPE***

The infographic is titled "HPE Coverage Groups" in a large, bold, blue font at the bottom. It is divided into two main sections, each with a colored header bar. The first section, "Former Foster Care Children", has a purple header bar and lists one bullet point: "Individual who is under 26 years of age and who, on the individuals' 18th birthday, was in foster care under the responsibility of the state". The second section, "Family Planning", has a teal header bar and lists two bullet points: "Non-pregnant women between 19 and 44" and "Coverage is limited to family planning related services including birth control, counseling, exams and tests". The entire content is enclosed in a dark blue border.

**Former Foster Care Children**

- Individual who is under 26 years of age and who, on the individuals' 18th birthday, was in foster care under the responsibility of the state

**Family Planning**

- Non-pregnant women between 19 and 44
- Coverage is limited to family planning related services including birth control, counseling, exams and tests

**HPE Coverage Groups**

### 1.19 Populations Eligible for HPE

Breast and Cervical Cancer

*Prior to any treatment, refer to a provider that has been designated by the Louisiana Breast and Cervical Health Program (LBCHP) to perform breast and cervical cancer screenings.*

*Referral must be done in order to avoid future disqualification for full Medicaid benefits.*

- Uninsured women under age 65
- Identified through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program

**HPE Coverage Groups**

### ***1.20 Duration of Eligibility under HPE***

## **Duration of Eligibility under HPE**

- HPE period begins with, and includes, the day on which the hospital makes the HPE determination
- HPE period ends:
  - The day on which the state makes the eligibility determination for Louisiana Medicaid, or
  - The last day of the month following the month in which the hospital makes the HPE determination, if the individual does not file a Louisiana Medicaid application by that time
  - Example (for someone who does not file a Medicaid Application):
    - Determination Date: 01-13-2014
    - HPE Period End Date: 02-28-2014
- The HPE period is limited to ***one per 12 month period or 1 per pregnancy***

### ***1.21 Determining Household Size and Income Sources***

## **Determining Household Size and Income**

- HPE Qualified Entities will receive additional training via the Learning Management System after successful completion of this HPE Module.

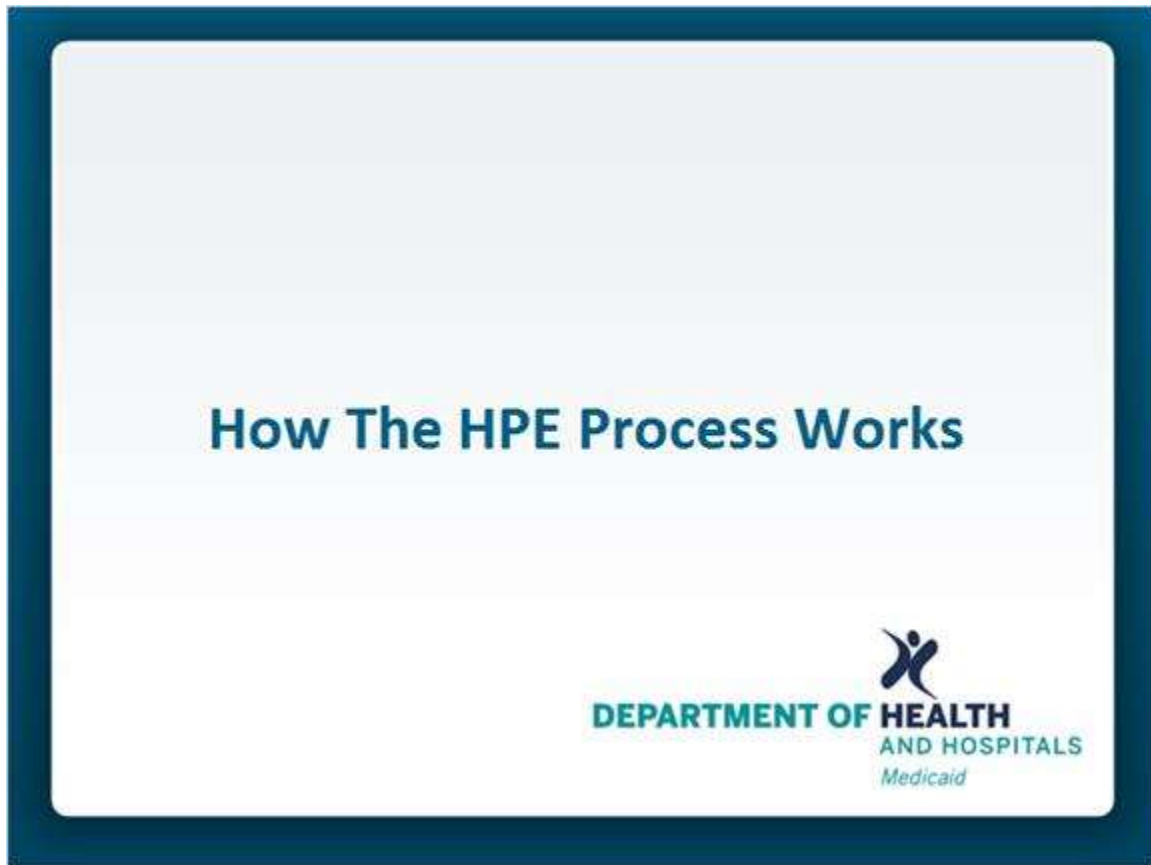


### ***1.22 Covered Services Under HPE***

## **Covered Services Under HPE**

- Benefits are the same as those provided under the Medicaid group for which the individual is determined presumptively eligible
  - For example: Family planning group - benefits limited to family planning services and supplies
- Exceptions
  - Pregnant women - benefits limited to ambulatory prenatal care (birthing expenses are not covered)

### ***1.23 How The HPE Process Works***



## 1.24 The HPE Determination Process

### The HPE Determination Process

HPE representative should take the following steps:

1. Confirm whether or not individual is enrolled in LA Medicaid
2. Complete BHSF Form 1-HPE if not already enrolled
  - a. Confirm US citizenship status and LA residency
  - b. Determine if the individual falls within an HPE Coverage Group;
  - c. Confirm income eligibility for HPE
3. Fax copy of BHSF Form 1-HPE to Louisiana Medicaid at 225-389-2741 or toll free at 877-747-0985
4. Provide a copy of BHSF Form 1-HPE to the Individual as proof of eligibility
5. Summarize benefits and answer any questions
6. Encourage application for full Medicaid and assist Individual by
  - a. *Referring the Individual to an Application Center*
  - b. *Referral to the Louisiana Medicaid Online Application*
  - c. *Referral to the Louisiana Medicaid Customer Service Hotline to apply by phone*
  - d. *Providing Individual with a BHSF 1- A paper application*

### **1.25 BHSF Form 1-HPE**

#### **BHSF Form 1-HPE**

- A tool for collecting information
- Individual's attestation of financial and other circumstances at the time of assessment
- HPE Representative's attestation that they have verified the individual has not received HPE in the past 12 months and is not currently enrolled in Louisiana Medicaid

### 1.26 Scroll the mouse wheel

Date of Interview 01/17/2014 Parish of Residence CADDO

Before you fill out the last section of the BHSF 1-HPE, verify that the individual is income eligible according to the Z-200 chart on the next screen.

Total Household income from the column above 10,17.00

☐ Yes ☒ No

## 1.27 Click and drag

Indiana Medicaid Eligibility Manual
Chat

FEDERAL POVERTY INCOME GUIDELINES  
Z – 200  
For Programs Changes Effective January 1, 2014

Family Size	24% Monthly	100% Monthly	120% Monthly	255% Monthly	300% Monthly
1	230	958	1,149	2,442	2,873
2	311	1,293	1,551	3,296	3,878
3	391	1,628	1,953	4,151	4,883
4	471	1,963	2,355	5,005	5,888
5	552	2,298	2,757	5,859	6,893
6	632	2,633	3,159	6,713	7,898
7	713	2,968	3,561	7,568	8,903
8	793	3,303	3,963	8,422	9,908

VIEW THE Z-200  
CHART FOR THE  
INCOME GUIDELINES

81	Add to the 24% monthly for each additional family member	4,820	Add to the 100% yearly for each additional family member
335	Add to the 100% monthly for each additional family member	4,824	Add to the 120% yearly for each additional family member
402	Add to the 120% monthly for each additional family member	5,427	Add to the 135% yearly for each additional family member
453	Add to the 135% monthly for each additional family member	5,548	Add to the 138% yearly for each additional family member
463	Add to the 138% monthly for each additional family member	5,910	Add to the 147% yearly for each additional family member
493	Add to the 147% monthly for each additional family member	8,040	Add to the 200% yearly for each additional family member
670	Add to the 200% monthly for each additional family member	8,603	Add to the 214% yearly for each additional family member
717	Add to the 214% monthly for each additional family member	8,643	Add to the 215% yearly for each additional family member
721	Add to the 215% monthly for each additional family member	8,724	Add to the 217% yearly for each additional family member
727	Add to the 217% monthly for each additional family member	11,073	Add to the 255% yearly for each additional family member
855	Add to the 255% monthly for each additional family member	12,060	Add to the 300% yearly for each additional family member
1,005	Add to the 300% monthly for each additional family member		

CHAMP (Children 6 to 18) Income is less than or equal to 147% FPG	Parents/Caretakers Income is less than or equal to 24% FPG
Pregnant Women Income less than or equal to 138% FPG	Take Charge Income less than or equal to 215% FPG
LaCHIP Income is less than or equal to 217% FPG	Medicaid Purchase Plan (MPP) Income less than or equal to 100% FPG
LaCHIP IV (Unborn Option) Income is less than or equal to 214% FPG	Family Opportunity Act (FOA) Income less than or equal to 300% FPG
LAP (LaCHIP Affordable Plan) Income does not exceed 255% FPG	

issued January 1, 2014
Page 1 of Z-200

Words: 1,144
100%

## 1.28 Click Microsoft Word Document

Indiana Medicaid Eligibility Manual

Chart

**FEDERAL POVERTY INCOME GUIDELINES**  
**Z - 200**  
**For Programs Changes Effective January 1, 2014**

Family Size	24% Monthly	100% Monthly	120% Monthly	135% Monthly	138% Monthly	147% Monthly	200% Monthly	214% Monthly	215% Monthly	217% Monthly	255% Monthly	300% Monthly
1	230	958	1,149	1,293	1,322	1,408	1,915	2,050	2,059	2,078	2,442	2,873
2	311	1,293	1,551	1,745	1,784	1,900	2,585	2,766	2,779	2,805	3,296	3,878
3	391	1,628	1,953	2,198	2,245	2,387	3,255	3,483	3,500	3,530	4,151	4,983

Look at the bottom of the Z-200 chart to choose the appropriate program and the corresponding FPIG.

We are considering Pregnant Woman for Jane Doe. The corresponding FPIG is 138%.

<b>CHAMP</b> (Children 0 to 18) Income is less than or equal to 147% FPIG	<b>Parents/Caretakers</b> Income is less than or equal to 24% FPIG
<b>Pregnant Women</b> Income less than or equal to 138% FPIG	<b>Take Charge</b> Income less than or equal to 215% FPIG
<b>LaCHIP</b> Income is less than or equal to 217% FPIG	<b>Medicaid Purchase Plan (MPP)</b> Income less than or equal to 100% FPIG
<b>LaCHIP IV (Unborn Option)</b> Income is less than or equal to 214% FPIG	<b>Family Opportunity Act (FOA)</b> Income less than or equal to 300% FPIG
<b>LAP (LaCHIP Affordable Plan)</b> Income does not exceed 255% FPIG	

issued January 1, 2014

Page 1 of Z-200

Words: 1,144

100%

## 1.29 Click and drag

Indiana Medicaid Eligibility Manual

**FEDERAL POVERTY INCOME (FPIG) TABLE**  
Z - 200  
For Programs Changes Effective January 1, 2014

Since the FPIG is 138%, look at the top column and find 138%.

Family Size	24% Monthly	100% Monthly	120% Monthly	135% Monthly	138% Monthly	147% Monthly
1	230	958	1,149	1,293	1,322	1,408
2	311	1,293	1,551	1,745	1,784	1,900
3	391	1,628	1,953	2,198	2,246	2,393
4	471	1,963	2,355	2,650	2,709	2,885
5	552	2,298	2,757	3,102	3,171	3,378
6	632	2,633	3,159	3,554	3,633	3,870
7	713	2,968	3,561	4,007	4,096	4,363
8	793	3,303	3,963	4,459	4,558	4,855
					6,605	7,068
					7,101	7,167
					8,422	9,908

81 Add to the 24% monthly for each additional family member  
335 Add to the 100% monthly for each additional family member  
402 Add to the 120% monthly for each additional family member  
453 Add to the 135% monthly for each additional family member  
463 Add to the 138% monthly for each additional family member  
493 Add to the 147% monthly for each additional family member  
670 Add to the 200% monthly for each additional family member  
717 Add to the 214% monthly for each additional family member  
721 Add to the 215% monthly for each additional family member  
727 Add to the 217% monthly for each additional family member  
855 Add to the 255% monthly for each additional family member  
1,005 Add to the 300% monthly for each additional family member

965 Add to the 24% yearly for each additional family member  
4,020 Add to the 100% yearly for each additional family member  
4,824 Add to the 120% yearly for each additional family member  
5,427 Add to the 135% yearly for each additional family member  
5,548 Add to the 138% yearly for each additional family member  
5,910 Add to the 147% yearly for each additional family member  
8,040 Add to the 200% yearly for each additional family member  
8,603 Add to the 214% yearly for each additional family member  
8,643 Add to the 215% yearly for each additional family member  
8,724 Add to the 217% yearly for each additional family member  
11,073 Add to the 255% yearly for each additional family member  
12,060 Add to the 300% yearly for each additional family member

<b>CHAMP</b> (Children 0 to 18) Income is less than or equal to 147% FPIG	<b>Parents/Caretakers</b> Income is less than or equal to 24% FPIG
<b>Pregnant Women</b> Income less than or equal to 100% FPIG	<b>Take Charge</b> Income less than or equal to 215% FPIG
<b>LaCHIP</b> Income is less than or equal to 217% FPIG	<b>Medicaid Purchase Plan (MPP)</b> Income less than or equal to 100% FPIG
<b>LaCHIP IV (Unborn Option)</b> Income is less than or equal to 214% FPIG	<b>Family Opportunity Act (FOA)</b> Income less than or equal to 300% FPIG
<b>LAP (LaCHIP Affordable Plan)</b> Income does not exceed 255% FPIG	

issued January 1, 2014

Page 1 of Z-200

Words: 1,144

100%

### 1.30 Click and drag

**FEDERAL POVERTY INCOME GUIDELINES**  
Z - 200  
For Programs Changes Effective January 1, 2014

Family Size	24% Monthly	100% Monthly	120% Monthly	135% Monthly	138% Monthly	147% Monthly	200% Monthly	214% Monthly	215% Monthly	217% Monthly	255% Monthly	300% Monthly
1	230	958	1,149	1,293	1,322	1,408	1,915	2,050	2,059	2,078	2,442	2,873
2	311	1,293	1,551	1,745	1,784	1,900	2,585	2,766	2,779	2,805	3,296	3,878
3	391	1,628	1,953	2,198	2,246	2,393	3,255	3,483	3,500	3,532	4,151	4,883
4	471										5,005	5,888
5	552										5,859	6,893
6	632										6,713	7,898
7	713										7,568	8,903
8	793										8,422	9,908

81 Add to the 24%  
335 Add to the 100%  
402 Add to the 120%  
453 Add to the 135%  
463 Add to the 138%  
493 Add to the 147%  
670 Add to the 200%  
717 Add to the 214%  
721 Add to the 215%  
727 Add to the 217%  
855 Add to the 255%  
1,005 Add to the 300%

Now you will look at the column Family Size.  
Jane Doe's household consists of herself and her unborn child (2).  
You will look across row 2 for family size and down 138% column. Where these two intersect, is the limit for Jane Doe's household.

CHAMP (Children 0 to 2)	24% FPIG
Pregnant Women (Income less than or equal to 138% FPIG)	Take Charge (Income less than or equal to 215% FPIG)
LaCHIP (Income is less than or equal to 217% FPIG)	LaCHIP IV (Unborn Option) (Income is less than or equal to 214% FPIG)

### 1.31 Click and drag

**FEDERAL POVERTY INCOME GUIDELINES**  
Z - 200  
For Programs Changes Effective January 1, 2014

Family Size	24% Monthly	100% Monthly	120% Monthly	135% Monthly	138% Monthly	147% Monthly	200% Monthly	214% Monthly	215% Monthly	217% Monthly	255% Monthly	300% Monthly
1	230	958	1,149	1,293	1,322	1,408	1,915	2,050	2,059	2,078	2,442	2,873
2	311	1,293	1,551	1,745	1,784	1,900	2,585	2,766	2,779	2,805	3,296	3,878
3	391	1,628	1,953	2,198	2,246	2,393	3,255	3,483	3,500	3,532	4,151	4,883
4	471	1,963	2,355	2,650	2,700	2,895	3,825	4,090	4,120	4,259	5,005	5,888
5	552	2,298	2,755	3,100	3,150	3,395	4,425	4,730	4,760	4,900	5,755	6,738
6	632	2,633	3,155	3,550	3,600	3,895	5,025	5,370	5,400	5,550	6,505	7,588
7	713	2,968	3,555	4,000	4,050	4,395	5,625	5,990	6,020	6,170	7,205	8,388
8	793	3,303	3,955	4,450	4,500	4,895	6,225	6,610	6,640	6,790	8,005	9,288

81 Add to the 2  
335 Add to the 1  
402 Add to the 1  
453 Add to the 1  
463 Add to the 1  
493 Add to the 1  
670 Add to the 2  
717 Add to the 2  
721 Add to the 2  
727 Add to the 2  
855 Add to the 2  
1,005 Add to the 3

Jane Doe is income eligible for HPE Coverage Group Pregnant Woman since her income of \$1011.00 is less than the \$1784.00. Now you will fill out the last portion of the BHSF 1-HPE.

for each additional family member  
y for each additional family member  
y for each additional family member  
y for each additional family member  
y for each additional family member  
y for each additional family member  
y for each additional family member  
y for each additional family member  
y for each additional family member  
y for each additional family member  
y for each additional family member  
y for each additional family member

<b>CHAMP</b> (Children 0 to 18) Income is less than or equal to 147% FPIG	<b>Parents/Caretakers</b> Income is less than or equal to 24% FPIG
<b>Pregnant Women</b> Income less than or equal to 138% FPIG	<b>Take Charge</b> Income less than or equal to 215% FPIG
<b>LaCHIP</b> Income is less than or equal to 217% FPIG	<b>LaCHIP IV (Unborn Option)</b> Income is less than or equal to 214% FPIG

### 1.32 How to Make a Determination

## How to Make a Determination

- Once the Individual is assessed as presumptively eligible, the HPEQE should **FAX** the BHSF Form 1-HPE to Louisiana Medicaid **877-747-0985** within 5 business days.



### ***1.33 Connecting to Louisiana Medicaid Coverage Outside the Hospital***

#### **Connecting to Louisiana Medicaid Coverage Outside the Hospital**

Individuals can apply for full Medicaid coverage via:

- Online: [LA Medicaid Online Application](#)
- Phone: Medicaid Customer Service Hotline 888-342-6207
- In Person:
  - [Application Center](#)
  - [Local Medicaid Office](#)
- Submit a paper [BHSF 1-A Application](#)
- Fax: 877-523-2987
- Mail: Medicaid Application Office  
P.O. Box 91278  
Baton Rouge, LA 70821-9893

### ***1.34 State Hospital Presumptive Eligibility Contact and Additional Resources***

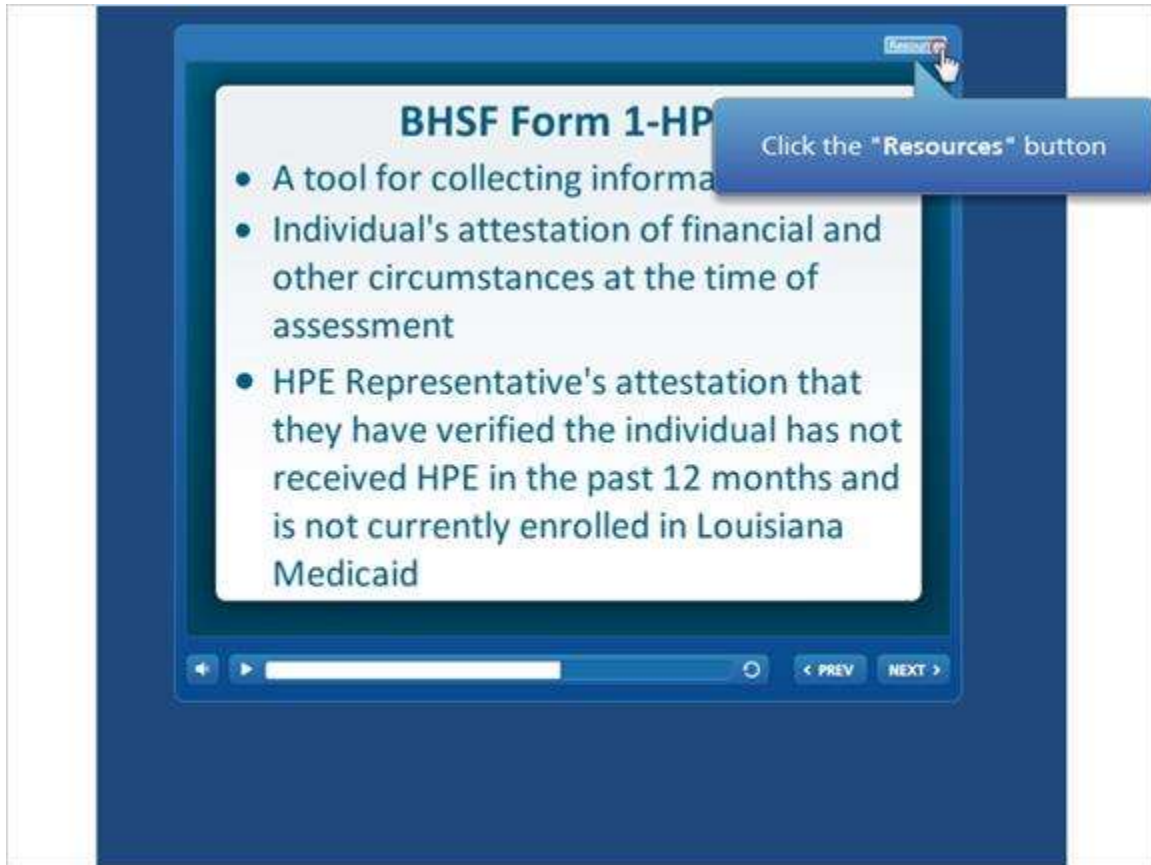
## **State Hospital Presumptive Eligibility Contact and Additional Resources**

- For questions or more information on Louisiana's Hospital Presumptive Eligibility policies, please contact:
  - *Kate Honeycutt, (225)342-0441*
  - *HPE@LA.gov*



## 2. BHSF FORM 1-HPE

### 2.1 Click the *Resources* button



## 2.2 Click the BHSF FORM 1-HPE label



## 2.3 Type 01/20/2014

**SHSF FORM 1-HPE**  
 REV 06/06

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: \_\_\_\_\_

Facility: \_\_\_\_\_ LA Medicaid HPE Provider #: \_\_\_\_\_

Type the Date of Assessment, Facility Name and LA Medicaid HPE Provider #

<b>Section A. HPE Responsible person</b>					
Name	Social Security Number (optional)				
Mailing Address (include City, State, Zip Code)	Daytime Phone				
Street Address (if different) (include City, State, Zip Code)	Other Phone				
E-mail Address	Parish of Residence				
Minor Child's Name	Date of birth				
	Social Security Number (optional)				
<b>Section B. Screening Questions for HPE Individual</b>					
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input type="checkbox"/>				
2. Are you a US Citizen?	<input type="checkbox"/> YN <input type="checkbox"/>				
3. Are you a Louisiana resident?	<input type="checkbox"/> YN <input type="checkbox"/>				
4. Are you pregnant?	<input type="checkbox"/> YN <input type="checkbox"/>				
5. Do you receive Medicare?	<input type="checkbox"/> YN <input type="checkbox"/>				
6. Do you currently receive Medicaid/LaChip?	<input type="checkbox"/> YN <input type="checkbox"/>				
7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input type="checkbox"/>				
8. What is your expected delivery date?					
<b>Section C. Category/Income Assessment</b>					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
			HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

## 2.4 Press Capital

OHMF FORM 1-HPE  
REV 08/08

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: 01/20/2014

Facility: \_\_\_\_\_ LA Medicaid/HPE Provider #: \_\_\_\_\_

<b>Section A. HPE Individual Information:</b> <small>If individual is a minor child, complete for the responsible person</small>					
Name		Date of Birth		Social Security Number (optional)	
Mailing Address (include City, State, Zip Code)				Daytime Phone	
Street Address (if different) (include City, State, Zip Code)				Other Phone	
E-mail Address				Parish of Residence	
Minor Child's Name		Date of birth		Social Security Number (optional)	

<b>Section B. Screening Questions for HPE Individual</b>					
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	5. Do you receive Medicare?	<input type="checkbox"/> YN <input type="checkbox"/>		
2. Are you a US Citizen?	<input type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?	<input type="checkbox"/> YN <input type="checkbox"/>		
3. Are you a Louisiana resident?	<input type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input type="checkbox"/>		
4. Are you pregnant?	<input type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?			

<b>Section C. Category/Income Assessment</b>					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
			HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

## 2.5 Type GENERAL HOSPITAL

BHSF FORM 1.HPE  
REV 06/06

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: 01/20/2014

Facility: \_\_\_\_\_ LA Medicaid/HPE Provider #: \_\_\_\_\_

<b>Section A. HPE Individual Information:</b> <i>If individual is a minor child, complete for the responsible person</i>		
Name	Date of Birth	Social Security Number (optional)
Mailing Address (include City, State, Zip Code)		Daytime Phone
Street Address (if different) (include City, State, Zip Code)		Other Phone
E-mail Address		Parish of Residence
Minor Child's Name	Date of birth	Social Security Number (optional)

<b>Section B. Screening Questions for HPE Individual</b>			
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input type="checkbox"/>	5. Do you receive Medicare?	<input type="checkbox"/> YN <input type="checkbox"/>
2. Are you a US Citizen?	<input type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?	<input type="checkbox"/> YN <input type="checkbox"/>
3. Are you a Louisiana resident?	<input type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input type="checkbox"/>
4. Are you pregnant?	<input type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?	

<b>Section C. Category/Income Assessment</b>					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
			HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

## 2.6 Type ABC123

BHSF FORM 1.HPE  
REV 08/08

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: 01/20/2014

Facility: GENERAL HOSPITAL LA Medicaid/HPE Provider #                     

<b>Section A. HPE Individual Information:</b> <small>If individual is a minor child, complete for the responsible person</small>		
Name	Date of Birth	Social Security Number (optional)
Mailing Address (include City, State, Zip Code)		Daytime Phone
Street Address (if different) (include City, State, Zip Code)		Other Phone
E-mail Address		Parish of Residence
Minor Child's Name	Date of birth	Social Security Number (optional)

<b>Section B. Screening Questions for HPE Individual</b>			
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input type="checkbox"/>	5. Do you receive Medicare?	<input type="checkbox"/> YN <input type="checkbox"/>
2. Are you a US Citizen?	<input type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?	<input type="checkbox"/> YN <input type="checkbox"/>
3. Are you a Louisiana resident?	<input type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input type="checkbox"/>
4. Are you pregnant?	<input type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?	

<b>Section C. Category/Income Assessment</b>					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
			HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

## 2.7 Type JANE DOE

SHSF FORM 1-HPE  
REV 08/08

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL** LA Medicaid HPE Provider #: **ABC123**

Section A. HPE Individual Information: <i>If individual is a minor child, complete for the responsible person</i>		
Name	Date of Birth	Social Security Number (optional)
Mailing Address (include City, State, Zip Code)		Daytime Phone
Street Address (if different) (include City, State, Zip Code)		Other Phone
E-mail Address		Parish of Residence
Minor Child's Name	Date of birth	Social Security Number (optional)

**If the individual needing HPE is a minor child, the Responsible Person's information will go here.**

4. Are you pregnant?	<input type="checkbox"/> Y <input type="checkbox"/> N	8. What is your expected delivery date?	
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**Section C. Category/Income Assessment**

NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?		INCOME
			HPE Individual	<input type="checkbox"/> Y	<input type="checkbox"/> N	
				<input type="checkbox"/> Y	<input type="checkbox"/> N	
				<input type="checkbox"/> Y	<input type="checkbox"/> N	

## 2.8 Type 01/17/1984

SHSF FORM 1-HPE  
REV 06/06

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL**      LA Medicaid/HPE Provider #: **ABC123**

<b>Section A. HPE Individual Information:</b> <small>If individual is a minor child, complete for the responsible person</small>					
Name <b>JANE DOE</b>		Date of Birth		Social Security Number (optional)	
Mailing Address (include City, State, Zip Code)				Daytime Phone	
Street Address (if different) (include City, State, Zip Code)				Other Phone	
E-mail Address				Parish of Residence	
Minor Child's Name		Date of birth		Social Security Number (optional)	

<b>Section B. Screening Questions for HPE Individual</b>					
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	5. Do you receive Medicare?	<input type="checkbox"/> YN <input type="checkbox"/>		
2. Are you a US Citizen?	<input type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?	<input type="checkbox"/> YN <input type="checkbox"/>		
3. Are you a Louisiana resident?	<input type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input type="checkbox"/>		
4. Are you pregnant?	<input type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?			

<b>Section C. Category/Income Assessment</b>					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
			HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

## 2.9 Type 111-11-1111

SHSF FORM 1-HPE  
REV 08/08

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL**      LA Medicaid/HPE Provider #: **ABC123**

<b>Section A. HPE Individual Information:</b> <small>If individual is a minor child, complete for the responsible person</small>						
Name <b>JANE DOE</b>	Date of Birth <b>01/17/1984</b>	Social Security Number (optional) 				
Mailing Address (include City, State, Zip Code)		Daytime Phone				
Street Address (if different) (include City, State, Zip Code)		Other Phone				
E-mail Address		Parish of Residence				
Minor Child's Name	Date of birth	Social Security Number (optional)				
<b>Section B. Screening Questions for HPE Individual</b>						
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	5. Do you receive Medicare?				
2. Are you a US Citizen?	<input type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?				
3. Are you a Louisiana resident?	<input type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?				
4. Are you pregnant?	<input type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?				
<b>Section C. Category/Income Assessment</b>						
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?		INCOME
			HPE Individual	<input type="checkbox"/> Y	<input type="checkbox"/> N	
				<input type="checkbox"/> Y	<input type="checkbox"/> N	
				<input type="checkbox"/> Y	<input type="checkbox"/> N	

## 2.10 Type 123 APPLE ST, SHREVEPORT, LA 71105

OHSF FORM 1.HPE  
REV 06/06

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL** LA Medicaid/HPE Provider #: **ABC123**

<b>Section A. HPE Individual Information:</b> <i>If individual is a minor child, complete for the responsible person</i>						
Name <b>JANE DOE</b>		Date of Birth <b>01/17/1984</b>		Social Security Number (optional) <b>111-11-1111</b>		
Mailing Address (include City, State, Zip Code)				Daytime Phone		
Street Address (if different) (include City, State, Zip Code)				Other Phone		
E-mail Address				Parish of Residence		
Minor Child's Name		Date of birth		Social Security Number (optional)		
<b>Section B. Screening Questions for HPE Individual</b>						
1. Have you received HPE within the last 12 months? Or for this pregnancy?		<input checked="" type="checkbox"/> YN <input type="checkbox"/>		5. Do you receive Medicare? <input type="checkbox"/> YN <input type="checkbox"/>		
2. Are you a US Citizen?		<input type="checkbox"/> YN <input type="checkbox"/>		6. Do you currently receive Medicaid/LaChip? <input type="checkbox"/> YN <input type="checkbox"/>		
3. Are you a Louisiana resident?		<input type="checkbox"/> YN <input type="checkbox"/>		7. Were you a foster child at age 18? <input type="checkbox"/> YN <input type="checkbox"/>		
4. Are you pregnant?		<input type="checkbox"/> YN <input type="checkbox"/>		8. What is your expected delivery date?		
<b>Section C. Category/Income Assessment</b>						
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?		INCOME
			HPE Individual	<input type="checkbox"/> Y	<input type="checkbox"/> N	
				<input type="checkbox"/> Y	<input type="checkbox"/> N	
				<input type="checkbox"/> Y	<input type="checkbox"/> N	

## 2.11 Type 318-555-1234

SHSF FORM 1-HPE  
REV 08/08

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL**      LA Medicaid/HPE Provider #: **ABC123**

<b>Section A. HPE Individual Information:</b> <small>If individual is a minor child, complete for the responsible person</small>		
Name <b>JANE DOE</b>	Date of Birth <b>01/17/1984</b>	Social Security Number (optional) <b>111-11-1111</b>
Mailing Address (include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>		Daytime Phone
Street Address (if different) (include City, State, Zip Code)		Other Phone
E-mail Address		Parish of Residence
Minor Child's Name	Date of birth	Social Security Number (optional)

<b>Section B. Screening Questions for HPE Individual</b>			
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input type="checkbox"/>	5. Do you receive Medicare?	<input type="checkbox"/> YN <input type="checkbox"/>
2. Are you a US Citizen?	<input type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?	<input type="checkbox"/> YN <input type="checkbox"/>
3. Are you a Louisiana resident?	<input type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input type="checkbox"/>
4. Are you pregnant?	<input type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?	

<b>Section C. Category/Income Assessment</b>					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
			HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

## 2.12 Type SAME

BHSF FORM 1.HPE  
REV 06/06

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL** LA Medicaid/HPE Provider #: **ABC123**

<b>Section A. HPE Individual Information: If individual is a minor child, complete for the responsible person</b>		
Name <b>JANE DOE</b>	Date of Birth <b>01/17/1984</b>	Social Security Number (optional) <b>111-11-1111</b>
Mailing Address (include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>		Daytime Phone <b>318-555-1234</b>
Street Address (if different) (include City, State, Zip Code)		Other Phone
E-mail Address		Parish of Residence
Minor Child's Name	Date of birth	Social Security Number (optional)

<b>Section B. Screening Questions for HPE Individual</b>			
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input checked="" type="checkbox"/>	YN	5. Do you receive Medicare?
2. Are you a US Citizen?	<input type="checkbox"/>	YN	6. Do you currently receive Medicaid/LaChip?
3. Are you a Louisiana resident?	<input type="checkbox"/>	YN	7. Were you a foster child at age 18?
4. Are you pregnant?	<input type="checkbox"/>	YN	8. What is your expected delivery date?

<b>Section C. Category/Income Assessment</b>					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
			HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

## 2.13 Type 318-779-1111

BHSF FORM 1.HPE  
REV 06/06

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL** LA Medicaid/HPE Provider #: **ABC123**

<b>Section A. HPE Individual Information:</b> <i>If individual is a minor child, complete for the responsible person</i>		
Name <b>JANE DOE</b>	Date of Birth <b>01/17/1984</b>	Social Security Number (optional) <b>111-11-1111</b>
Mailing Address (include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>		Daytime Phone <b>318-555-1234</b>
Street Address (if different) (include City, State, Zip Code) <b>SAME</b>		Other Phone
E-mail Address		Parish of Residence
Minor Child's Name	Date of birth	Social Security Number (optional)

<b>Section B. Screening Questions for HPE Individual</b>			
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	5. Do you receive Medicare?	<input type="checkbox"/> YN <input type="checkbox"/>
2. Are you a US Citizen?	<input type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?	<input type="checkbox"/> YN <input type="checkbox"/>
3. Are you a Louisiana resident?	<input type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input type="checkbox"/>
4. Are you pregnant?	<input type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?	

<b>Section C. Category/Income Assessment</b>						
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?		INCOME
			HPE Individual	<input type="checkbox"/> Y	<input type="checkbox"/> N	
				<input type="checkbox"/> Y	<input type="checkbox"/> N	
				<input type="checkbox"/> Y	<input type="checkbox"/> N	

## 2.14 Type JANEDOE@EXAMPLE.COM

0HSF FORM 1.HPE  
REV 06/06

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: 01/20/2014

Facility: GENERAL HOSPITAL LA Medicaid/HPE Provider #: ABC123

Section A. HPE Individual Information: <small>If individual is a minor child, complete for the responsible person</small>		
Name <b>JANE DOE</b>	Date of Birth <b>01/17/1984</b>	Social Security Number (optional) <b>111-11-1111</b>
Mailing Address (include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>		Daytime Phone <b>318-555-1234</b>
Street Address (if different) (include City, State, Zip Code) <b>SAME</b>		Other Phone <b>318-779-1111</b>
E-mail Address		Parish of Residence
Minor Child's Name	Date of birth	Social Security Number (optional)

Section B. Screening Questions for HPE Individual			
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	5. Do you receive Medicare?	<input type="checkbox"/> YN <input type="checkbox"/>
2. Are you a US Citizen?	<input type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?	<input type="checkbox"/> YN <input type="checkbox"/>
3. Are you a Louisiana resident?	<input type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input type="checkbox"/>
4. Are you pregnant?	<input type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?	

Section C. Category/Income Assessment					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
			HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

## 2.15 Type CADDO

BHSF FORM 1.HPE  
REV 08/08

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL** LA Medicaid/HPE Provider #: **ABC123**

<b>Section A. HPE Individual Information: If individual is a minor child, complete for the responsible person</b>		
Name <b>JANE DOE</b>	Date of Birth <b>01/17/1984</b>	Social Security Number (optional) <b>111-11-1111</b>
Mailing Address (include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>		Daytime Phone <b>318-555-1234</b>
Street Address (if different) (include City, State, Zip Code) <b>SAME</b>		Other Phone <b>318-779-1111</b>
E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence
Minor Child's Name	Date of birth	Social Security Number (optional)

<b>Section B. Screening Questions for HPE Individual</b>			
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	5. Do you receive Medicare?	<input type="checkbox"/> YN <input type="checkbox"/>
2. Are you a US Citizen?	<input type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?	<input type="checkbox"/> YN <input type="checkbox"/>
3. Are you a Louisiana resident?	<input type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input type="checkbox"/>
4. Are you pregnant?	<input type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?	

<b>Section C. Category/Income Assessment</b>					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
			HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

## 2.16 Press Tab

SHSF FORM 1 HPE  
REV 08/08

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL** LA Medicaid HPE Provider #: **ABC123**

Section A. HPE Individual Information: <i>If individual is a minor child, complete for the responsible person</i>		
Name	Date of Birth	Social Security Number (optional)
JANE DOE	01/17/1984	111-11-1111
Mailing Address (include City, State, Zip Code)		Daytime Phone
123 APPLE ST, SHREVEPORT, LA 71105		318-555-1234
Street Address (if different) (include City, State, Zip Code)		Other Phone
SAME		318-779-1111
E-mail Address		Parish of Residence
JANEDOE@EXAMPLE.COM		CADDO
Minor Child's Name	Date of birth	Social Security Number (optional)

If the individual needing HPE is a minor child, the child's information will go here.

4. Are you pregnant?		<input type="checkbox"/> Y <input type="checkbox"/> N	8. What is your expected delivery date?		
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Section C. Category/Income Assessment					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
			HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

## 2.17 Press Tab

BMSF FORM 1-HPE  
REV 10/09

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment 01/20/2014

Facility GENERAL HOSPITAL LA Medicaid/HPE Provider # ABC123

Section A. HPE Individual Information: <i>If individual is a minor child, complete for the responsible person</i>		
Name <b>JANE DOE</b>	Date of Birth <b>01/17/1984</b>	Social Security Number (optional) <b>111-11-1111</b>
Mailing Address (include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>		Daytime Phone <b>318-555-1234</b>
Street Address (if different) (include City, State, Zip Code)		Other Phone

**Section B: Applicant Screening Questions**  
Answer the questions  
based on the individual's response.  
**NO ADDITIONAL VERIFICATION ALLOWED.**

4. Are you pregnant?	<input type="checkbox"/> Y <input type="checkbox"/> N	8. What is your expected delivery date?	
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**Section C. Category/Income Assessment**

NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?		INCOME
			HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N		
				<input type="checkbox"/> Y <input type="checkbox"/> N		
				<input type="checkbox"/> Y <input type="checkbox"/> N		

## 2.18 Press Tab

0HSF FORM 1.HPE  
REV 06/06

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL** LA Medicaid/HPE Provider #: **ABC123**

<b>Section A. HPE Individual Information: If individual is a minor child, complete for the responsible person</b>					
Name <b>JANE DOE</b>	Date of Birth <b>01/17/1984</b>	Social Security Number (optional) <b>111-11-1111</b>			
Mailing Address (include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>		Daytime Phone <b>318-555-1234</b>			
Street Address (if different) (include City, State, Zip Code) <b>SAME</b>		Other Phone <b>318-779-1111</b>			
E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>			
Minor Child's Name	Date of birth	Social Security Number (optional)			
<b>Section B. Screening Questions for HPE Individual</b>					
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	5. Do you receive Medicare? <input type="checkbox"/> YN <input type="checkbox"/>			
2. Are you a US Citizen?	<input type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip? <input type="checkbox"/> YN <input type="checkbox"/>			
3. Are you a Louisiana resident?	<input type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18? <input type="checkbox"/> YN <input type="checkbox"/>			
4. Are you pregnant?	<input type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?			
<b>Section C. Category/Income Assessment</b>					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
			HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

## 2.19 Click the panel

BHSF FORM 1.HPE  
REV 06/06

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL** LA Medicaid/HPE Provider #: **ABC123**

Section A. HPE Individual Information: <small>If individual is a minor child, complete for the responsible person</small>					
Name <b>JANE DOE</b>	Date of Birth <b>01/17/1984</b>	Social Security Number (optional) <b>111-11-1111</b>			
Mailing Address (include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>		Daytime Phone <b>318-555-1234</b>			
Street Address (if different) (include City, State, Zip Code) <b>SAME</b>		Other Phone <b>318-779-1111</b>			
E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>			
Minor Child's Name	Date of birth	Social Security Number (optional)			
<b>Section B. Screening Questions for HPE Individual</b>					
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input type="checkbox"/>	5. Do you receive Medicare? <input type="checkbox"/> YN <input type="checkbox"/>			
2. Are you a US Citizen?	<input type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip? <input type="checkbox"/> YN <input type="checkbox"/>			
3. Are you a Louisiana resident?	<input type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18? <input type="checkbox"/> YN <input type="checkbox"/>			
4. Are you pregnant?	<input type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?			
<b>Section C. Category/Income Assessment</b>					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
			HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

## 2.20 Click the panel

OHSF FORM 1-HPE  
REV 08/08

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL** LA Medicaid/HPE Provider #: **ABC123**

Section A. HPE Individual Information: <small>If individual is a minor child, complete for the responsible person</small>		
Name <b>JANE DOE</b>	Date of Birth <b>01/17/1984</b>	Social Security Number (optional) <b>111-11-1111</b>
Mailing Address (include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>		Daytime Phone <b>318-555-1234</b>
Street Address (if different) (include City, State, Zip Code) <b>SAME</b>		Other Phone <b>318-779-1111</b>
E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>
Minor Child's Name	Date of birth	Social Security Number (optional)

Section B. Screening Questions for HPE Individual			
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare?	<input type="checkbox"/> YN <input type="checkbox"/>
2. Are you a US Citizen?	<input type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?	<input type="checkbox"/> YN <input type="checkbox"/>
3. Are you a Louisiana resident?	<input type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input type="checkbox"/>
4. Are you pregnant?	<input type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?	

Section C. Category/Income Assessment					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
			HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

## 2.21 Click the panel

BHSF FORM 1 HPE  
REV 06/06

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL** LA Medicaid HPE Provider #: **ABC123**

Section A. HPE Individual Information: <small>If individual is a minor child, complete for the responsible person</small>		
Name <b>JANE DOE</b>	Date of Birth <b>01/17/1984</b>	Social Security Number (optional) <b>111-11-1111</b>
Mailing Address (include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>		Daytime Phone <b>318-555-1234</b>
Street Address (if different) (include City, State, Zip Code) <b>SAME</b>		Other Phone <b>318-779-1111</b>
E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>
Minor Child's Name	Date of birth	Social Security Number (optional)

Section B. Screening Questions for HPE Individual			
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare?	<input type="checkbox"/> YN <input type="checkbox"/>
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?	<input type="checkbox"/> YN <input type="checkbox"/>
3. Are you a Louisiana resident?	<input type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input type="checkbox"/>
4. Are you pregnant?	<input type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?	

Section C. Category/Income Assessment					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
			HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

## 2.22 Click the row

0HSF FORM 1.HPE  
REV 06/06

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL** LA Medicaid/HPE Provider #: **ABC123**

Section A. HPE Individual Information: <small>If individual is a minor child, complete for the responsible person</small>					
Name <b>JANE DOE</b>	Date of Birth <b>01/17/1984</b>	Social Security Number (optional) <b>111-11-1111</b>			
Mailing Address (include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>		Daytime Phone <b>318-555-1234</b>			
Street Address (if different) (include City, State, Zip Code) <b>SAME</b>		Other Phone <b>318-779-1111</b>			
E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>			
Minor Child's Name	Date of birth	Social Security Number (optional)			
<b>Section B. Screening Questions for HPE Individual</b>					
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare? <input type="checkbox"/> YN <input type="checkbox"/>			
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip? <input type="checkbox"/> YN <input type="checkbox"/>			
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18? <input type="checkbox"/> YN <input type="checkbox"/>			
4. Are you pregnant?	<input type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?			
<b>Section C. Category/Income Assessment</b>					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
			HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

## 2.23 Click the panel

0HSF FORM 1.HPE  
REV 06/06

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL** LA Medicaid/HPE Provider #: **ABC123**

Section A. HPE Individual Information: <small>If individual is a minor child, complete for the responsible person</small>					
Name <b>JANE DOE</b>	Date of Birth <b>01/17/1984</b>	Social Security Number (optional) <b>111-11-1111</b>			
Mailing Address (include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>		Daytime Phone <b>318-555-1234</b>			
Street Address (if different) (include City, State, Zip Code) <b>SAME</b>		Other Phone <b>318-779-1111</b>			
E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>			
Minor Child's Name	Date of birth	Social Security Number (optional)			
<b>Section B. Screening Questions for HPE Individual</b>					
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare? <input type="checkbox"/> YN <input type="checkbox"/>			
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip? <input type="checkbox"/> YN <input type="checkbox"/>			
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18? <input type="checkbox"/> YN <input type="checkbox"/>			
4. Are you pregnant?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?			
<b>Section C. Category/Income Assessment</b>					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
			HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

## 2.24 Click the panel

BHSF FORM 1-HPE  
REV 06/06

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL** LA Medicaid/HPE Provider #: **ABC123**

Section A. HPE Individual Information: <small>If individual is a minor child, complete for the responsible person</small>					
Name <b>JANE DOE</b>	Date of Birth <b>01/17/1984</b>	Social Security Number (optional) <b>111-11-1111</b>			
Mailing Address (include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>		Daytime Phone <b>318-555-1234</b>			
Street Address (if different) (include City, State, Zip Code) <b>SAME</b>		Other Phone <b>318-779-1111</b>			
E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>			
Minor Child's Name	Date of birth	Social Security Number (optional)			
Section B. Screening Questions for HPE Individual					
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare?			
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?			
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?			
4. Are you pregnant?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?			
Section C. Category/Income Assessment					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
			HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

## 2.25 Click the panel

BHSF FORM 1.HPE  
REV 06/06

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL** LA Medicaid/HPE Provider #: **ABC123**

Section A. HPE Individual Information: <small>If individual is a minor child, complete for the responsible person</small>					
Name <b>JANE DOE</b>	Date of Birth <b>01/17/1984</b>	Social Security Number (optional) <b>111-11-1111</b>			
Mailing Address (include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>		Daytime Phone <b>318-555-1234</b>			
Street Address (if different) (include City, State, Zip Code) <b>SAME</b>		Other Phone <b>318-779-1111</b>			
E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>			
Minor Child's Name	Date of birth	Social Security Number (optional)			
<b>Section B. Screening Questions for HPE Individual</b>					
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare?			
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?			
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?			
4. Are you pregnant?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?			
<b>Section C. Category/Income Assessment</b>					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
			HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

## 2.26 Click the panel

BHSF FORM 1 HPE  
REV 06/06

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL** LA Medicaid/HPE Provider #: **ABC123**

Section A. HPE Individual Information: <small>If individual is a minor child, complete for the responsible person</small>					
Name <b>JANE DOE</b>	Date of Birth <b>01/17/1984</b>	Social Security Number (optional) <b>111-11-1111</b>			
Mailing Address (include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>		Daytime Phone <b>318-555-1234</b>			
Street Address (if different) (include City, State, Zip Code) <b>SAME</b>		Other Phone <b>318-779-1111</b>			
E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>			
Minor Child's Name	Date of birth	Social Security Number (optional)			
Section B. Screening Questions for HPE Individual					
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare?			
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?			
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?			
4. Are you pregnant?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?			
Section C. Category/Income Assessment					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
			HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

## 2.27 Type 03/29/2014

BHSF FORM 1.HPE  
REV 06/06

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL** LA Medicaid/HPE Provider #: **ABC123**

<b>Section A. HPE Individual Information: If individual is a minor child, complete for the responsible person</b>					
Name <b>JANE DOE</b>	Date of Birth <b>01/17/1984</b>	Social Security Number (optional) <b>111-11-1111</b>			
Mailing Address (include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>		Daytime Phone <b>318-555-1234</b>			
Street Address (if different) (include City, State, Zip Code) <b>SAME</b>		Other Phone <b>318-779-1111</b>			
E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>			
Minor Child's Name	Date of birth	Social Security Number (optional)			
<b>Section B. Screening Questions for HPE Individual</b>					
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare?			
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?			
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?			
4. Are you pregnant?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?			
<b>Section C. Category/Income Assessment</b>					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
			HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

## 2.28 Type JANE DOE

SHSF FORM 1.HPE  
REV 06/06

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: 01/20/2014

Facility: GENERAL HOSPITAL LA Medicaid HPE Provider #: ABC123

Section A. HPE Individual Information: <i>If individual is a minor child, complete for the responsible person</i>		
Name	Date of Birth	Social Security Number (optional)
JANE DOE	01/17/1984	111-11-1111
Mailing Address (include City, State, Zip Code)		Daytime Phone
123 APPLE ST, SHREVEPORT, LA 71105		318-555-1234
Street Address (if different) (include City, State, Zip Code)		Other Phone
SAME		318-779-1111

**SECTION C: Category/Income Assessment**  
Additional Income and Household training  
will be in another module.  
Fill in the columns below based on answers  
given by the applicant.

NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?		INCOME
			HPE Individual	<input type="checkbox"/> Y	<input type="checkbox"/> N	
				<input type="checkbox"/> Y	<input type="checkbox"/> N	
				<input type="checkbox"/> Y	<input type="checkbox"/> N	

## 2.29 Type 01/17/1984

BHSF FORM 1 HPE  
REV 06/06

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL** LA Medicaid HPE Provider #: **ABC123**

<b>Section A. HPE Individual Information: If individual is a minor child, complete for the responsible person</b>						
Name <b>JANE DOE</b>	Date of Birth <b>01/17/1984</b>	Social Security Number (optional) <b>111-11-1111</b>				
Mailing Address (include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>		Daytime Phone <b>318-555-1234</b>				
Street Address (if different) (include City, State, Zip Code) <b>SAME</b>		Other Phone <b>318-779-1111</b>				
E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>				
Minor Child's Name	Date of birth	Social Security Number (optional)				
<b>Section B. Screening Questions for HPE Individual</b>						
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare?				
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?				
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?				
4. Are you pregnant?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?				
		<b>03/29/2014</b>				
<b>Section C. Category/Income Assessment</b>						
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?		INCOME
JANE DOE			HPE Individual	<input type="checkbox"/> Y	<input type="checkbox"/> N	
				<input type="checkbox"/> Y	<input type="checkbox"/> N	
				<input type="checkbox"/> Y	<input type="checkbox"/> N	

## 2.30 Type 111-11-1111

0HSF FORM 1 HPE  
REV 06/06

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL** LA Medicaid HPE Provider #: **ABC123**

<b>Section A. HPE Individual Information: If individual is a minor child, complete for the responsible person</b>					
Name <b>JANE DOE</b>	Date of Birth <b>01/17/1984</b>	Social Security Number (optional) <b>111-11-1111</b>			
Mailing Address (include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>		Daytime Phone <b>318-555-1234</b>			
Street Address (if different) (include City, State, Zip Code) <b>SAME</b>		Other Phone <b>318-779-1111</b>			
E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>			
Minor Child's Name	Date of birth	Social Security Number (optional)			
<b>Section B. Screening Questions for HPE Individual</b>					
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare?			
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?			
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?			
4. Are you pregnant?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?			
		<b>03/29/2014</b>			
<b>Section C. Category/Income Assessment</b>					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
JANE DOE	01/17/1984		HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

## 2.31 Click the panel

BHSF FORM 1.HPE  
REV 06/06

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL** LA Medicaid/HPE Provider #: **ABC123**

Section A. HPE Individual Information: <small>If individual is a minor child, complete for the responsible person</small>					
Name <b>JANE DOE</b>	Date of Birth <b>01/17/1984</b>	Social Security Number (optional) <b>111-11-1111</b>			
Mailing Address (include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>		Daytime Phone <b>318-555-1234</b>			
Street Address (if different) (include City, State, Zip Code) <b>SAME</b>		Other Phone <b>318-779-1111</b>			
E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>			
Minor Child's Name	Date of birth	Social Security Number (optional)			
<b>Section B. Screening Questions for HPE Individual</b>					
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare? <input type="checkbox"/> YN <input checked="" type="checkbox"/>			
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip? <input type="checkbox"/> YN <input checked="" type="checkbox"/>			
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18? <input type="checkbox"/> YN <input checked="" type="checkbox"/>			
4. Are you pregnant?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date? <b>03/29/2014</b>			
<b>Section C. Category/Income Assessment</b>					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
JANE DOE	01/17/1984	111-11-1111	HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

## 2.32 Type 1011.00

BHSF FORM 1 HPE  
REV 08/08

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL** LA Medicaid HPE Provider #: **ABC123**

<b>Section A. HPE Individual Information: If individual is a minor child, complete for the responsible person</b>						
Name <b>JANE DOE</b>	Date of Birth <b>01/17/1984</b>	Social Security Number (optional) <b>111-11-1111</b>				
Mailing Address (include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>		Daytime Phone <b>318-555-1234</b>				
Street Address (if different) (include City, State, Zip Code) <b>SAME</b>		Other Phone <b>318-779-1111</b>				
E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>				
Minor Child's Name	Date of birth	Social Security Number (optional)				
<b>Section B. Screening Questions for HPE Individual</b>						
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare?				
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?				
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?				
4. Are you pregnant?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?				
		<b>03/29/2014</b>				
<b>Section C. Category/Income Assessment</b>						
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?		INCOME
JANE DOE	01/17/1984	111-11-1111	HPE Individual	<input type="checkbox"/> Y	<input type="checkbox"/> N	
				<input type="checkbox"/> Y	<input type="checkbox"/> N	
				<input type="checkbox"/> Y	<input type="checkbox"/> N	

## 2.33 Scroll the mouse wheel

SHSF FORM 1-HPE  
REV 08/08

**Louisiana Medicaid Hospital Presumptive Eligibility (HPE)  
Assessment Tool Only**

Date of Assessment: **01/20/2014**

Facility: **GENERAL HOSPITAL**      LA Medicaid/HPE Provider #: **ABC123**

<b>Section A. HPE Individual Information:</b> <small>If individual is a minor child, complete for the responsible person</small>						
Name <b>JANE DOE</b>	Date of Birth <b>01/17/1984</b>	Social Security Number (optional) <b>111-11-1111</b>				
Mailing Address (include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>		Daytime Phone <b>318-555-1234</b>				
Street Address (if different) (include City, State, Zip Code) <b>SAME</b>		Other Phone <b>318-779-1111</b>				
E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>				
Minor Child's Name	Date of birth	Social Security Number (optional)				
<b>Section B. Screening Questions for HPE Individual</b>						
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare?				
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?				
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?				
4. Are you pregnant?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?				
		<b>03/29/2014</b>				
<b>Section C. Category/Income Assessment</b>						
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?		INCOME
JANE DOE	01/17/1984	111-11-1111	HPE Individual	<input type="checkbox"/> Y	<input type="checkbox"/> N	1011.00
				<input type="checkbox"/> Y	<input type="checkbox"/> N	
				<input type="checkbox"/> Y	<input type="checkbox"/> N	

## 2.34 Click the panel

Section A. HPE Individual Information: <b>If individual is a minor child, complete for the responsible person</b>					
Name <b>JANE DOE</b>		Date of Birth <b>01/17/1984</b>		Social Security Number (optional) <b>111-11-1111</b>	
Mailing Address (Include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>				Daytime Phone <b>318-555-1234</b>	
Street Address (if different) (Include City, State, Zip Code) <b>SAME</b>				Other Phone <b>318-779-1111</b>	
E-mail Address <b>JANEDOE@EXAMPLE.COM</b>				Parish of Residence <b>CADDO</b>	
Minor Child's Name		Date of birth		Social Security Number (optional)	
Section B. Screening Questions for HPE Individual					
1. Have you received HPE within the last 12 months? Or for this pregnancy?		<input type="checkbox"/> YN <input checked="" type="checkbox"/>		5. Do you receive Medicare? <input type="checkbox"/> YN <input checked="" type="checkbox"/>	
2. Are you a US Citizen?		<input checked="" type="checkbox"/> YN <input type="checkbox"/>		6. Do you currently receive Medicaid/LaChip? <input type="checkbox"/> YN <input checked="" type="checkbox"/>	
3. Are you a Louisiana resident?		<input checked="" type="checkbox"/> YN <input type="checkbox"/>		7. Were you a foster child at age 18? <input type="checkbox"/> YN <input checked="" type="checkbox"/>	
4. Are you pregnant?		<input checked="" type="checkbox"/> YN <input type="checkbox"/>		8. What is your expected delivery date? <b>03/29/2014</b>	
Section C. Category/Income Assessment					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
JANE DOE	01/17/1984	111-11-1111	HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	1011.00
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
Total household income					
Based on the above attested information, _____ is presumptively eligible for <b>Pregnant Woman</b>					INCOME_Total hps

## 2.35 Type 1011.00

Section A. HPE Individual Information: <b>If individual is a minor child, complete for the responsible person</b>					
Name <b>JANE DOE</b>		Date of Birth <b>01/17/1984</b>		Social Security Number (optional) <b>111-11-1111</b>	
Mailing Address (Include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>				Daytime Phone <b>318-555-1234</b>	
Street Address (if different) (Include City, State, Zip Code) <b>SAME</b>				Other Phone <b>318-779-1111</b>	
E-mail Address <b>JANEDOE@EXAMPLE.COM</b>				Parish of Residence <b>CADDO</b>	
Minor Child's Name		Date of birth		Social Security Number (optional)	
Section B. Screening Questions for HPE Individual					
1. Have you received HPE within the last 12 months? Or for this pregnancy?		<input type="checkbox"/> YN <input checked="" type="checkbox"/>		5. Do you receive Medicare? <input type="checkbox"/> YN <input checked="" type="checkbox"/>	
2. Are you a US Citizen?		<input checked="" type="checkbox"/> YN <input type="checkbox"/>		6. Do you currently receive Medicaid/LaCHIP? <input type="checkbox"/> YN <input checked="" type="checkbox"/>	
3. Are you a Louisiana resident?		<input checked="" type="checkbox"/> YN <input type="checkbox"/>		7. Were you a foster child at age 18? <input type="checkbox"/> YN <input checked="" type="checkbox"/>	
4. Are you pregnant?		<input checked="" type="checkbox"/> YN <input type="checkbox"/>		8. What is your expected delivery date? <b>03/29/2014</b>	
Section C. Category/Income Assessment					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
JANE DOE	01/17/1984	111-11-1111	HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	1011.00
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
Total household income					
Based on the above attested information, <b>JANE DOE</b> is presumptively eligible for <b>Pregnant Woman</b>					

Add total household income.

## 2.36 Type JANE DOE

Section A. HPE Individual Information: <b>If individual is a minor child, complete for the responsible person</b>					
Name <b>JANE DOE</b>		Date of Birth <b>01/17/1984</b>		Social Security Number (optional) <b>111-11-1111</b>	
Mailing Address (Include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>				Daytime Phone <b>318-555-1234</b>	
Street Address (if different) (Include City, State, Zip Code) <b>SAME</b>				Other Phone <b>318-779-1111</b>	
E-mail Address <b>JANEDOE@EXAMPLE.COM</b>				Parish of Residence <b>CADDO</b>	
Minor Child's Name		Date of birth		Social Security Number (optional)	
Section B. Screening Questions for HPE Individual					
1. Have you received HPE within the last 12 months? Or for this pregnancy?		<input type="checkbox"/> YN <input checked="" type="checkbox"/>		5. Do you receive Medicare? <input type="checkbox"/> YN <input checked="" type="checkbox"/>	
2. Are you a US Citizen?		<input checked="" type="checkbox"/> YN <input type="checkbox"/>		6. Do you currently receive Medicaid/LaChip? <input type="checkbox"/> YN <input checked="" type="checkbox"/>	
3. Are you a Louisiana resident?		<input checked="" type="checkbox"/> YN <input type="checkbox"/>		7. Were you a foster child at age 18? <input type="checkbox"/> YN <input checked="" type="checkbox"/>	
4. Are you pregnant?		<input checked="" type="checkbox"/> YN <input type="checkbox"/>		8. What is your expected delivery date? <b>03/29/2014</b>	
Section C. Category/Income Assessment					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
JANE DOE	01/17/1984	111-11-1111	HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	1011.00
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
Total household income					1011.00
Based on the above attested information, _____ is presumptively eligible for <b>Pregnant Woman</b> .					

## 2.37 Scroll the mouse wheel

Section A. HPE Individual Information: <b>If individual is a minor child, complete for the responsible person</b>					
Name <b>JANE DOE</b>		Date of Birth <b>01/17/1984</b>		Social Security Number (optional) <b>111-11-1111</b>	
Mailing Address (Include City, State, Zip Code) <b>123 APPLE ST, SHREVEPORT, LA 71105</b>				Daytime Phone <b>318-555-1234</b>	
Street Address (if different) (Include City, State, Zip Code) <b>SAME</b>				Other Phone <b>318-779-1111</b>	
E-mail Address <b>JANEDOE@EXAMPLE.COM</b>				Parish of Residence <b>CADDO</b>	
Minor Child's Name		Date of birth		Social Security Number (optional)	
Section B. Screening Questions for HPE Individual					
1. Have you received HPE within the last 12 months? Or for this pregnancy?		<input type="checkbox"/> YN <input checked="" type="checkbox"/>		5. Do you receive Medicare? <input type="checkbox"/> YN <input checked="" type="checkbox"/>	
2. Are you a US Citizen?		<input checked="" type="checkbox"/> YN <input type="checkbox"/>		6. Do you currently receive Medicaid/LaChip? <input type="checkbox"/> YN <input checked="" type="checkbox"/>	
3. Are you a Louisiana resident?		<input checked="" type="checkbox"/> YN <input type="checkbox"/>		7. Were you a foster child at age 18? <input type="checkbox"/> YN <input checked="" type="checkbox"/>	
4. Are you pregnant?		<input checked="" type="checkbox"/> YN <input type="checkbox"/>		8. What is your expected delivery date? <b>03/29/2014</b>	
Section C. Category/Income Assessment					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
JANE DOE	01/17/1984	111-11-1111	HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	1011.00
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
Total household income					1011.00
Based on the above attested information, <b>JANE DOE</b> is presumptively eligible for <b>Pregnant Woman</b>					

## 2.38 Click the text box

E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>	
Minor Child's Name		Date of birth	Social Security Number (optional)

**Section B. Screening Questions for HPE Individual**

1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>
4. Are you pregnant?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?	<b>03/29/2014</b>

**Section C. Category/Income Assessment**

NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?		INCOME
JANE DOE	01/17/1984	111-11-1111	HPE Individual	<input type="checkbox"/> Y	<input type="checkbox"/> N	1011.00
				<input type="checkbox"/> Y	<input type="checkbox"/> N	
				<input type="checkbox"/> Y	<input type="checkbox"/> N	
				<input type="checkbox"/> Y	<input type="checkbox"/> N	
				<input type="checkbox"/> Y	<input type="checkbox"/> N	
				<input type="checkbox"/> Y	<input type="checkbox"/> N	
Total household income						1011.00

Based on the above attested information, **JANE DOE** is presumptively eligible for **Pregnant Woman** from  until  or until a determination is made if a Louisiana Medicaid application is submitted prior to the end date above. Individual was assisted in applying for Louisiana **HPEQE completed BHSF 1-A**. In the event a previous period of HPE eligibility was given within the last 12 months or for current pregnancy, individual was informed that this assessment will be derived.

HPE Representative's Signature <input type="text"/>	HPE Representative's email <input type="text"/>	HPE Representative's ID <input type="text"/>
HPE Representative's Printed Name <input type="text"/>	HPE Representative's Phone <input type="text"/>	Date <input type="text"/>

## 2.39 Click the text box

E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>	
Minor Child's Name		Date of birth	Social Security Number (optional)

Section B. Screening Questions for HPE Individual			
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaCHIP?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>
4. Are you pregnant?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?	<b>03/29/2014</b>

Section C. Category/Income Assessment					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
JANE DOE	01/17/1984	111-11-1111	HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	1011.00
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
Total household income					1011.00

Based on the above attested information, **JANE DOE** is presumptively eligible for **Pregnant Woman** from  until  or until a determination is made if a Louisiana Medicaid application is submitted prior to the end date above.

Individual was assisted in applying for Louisiana **HPEQE completed BHSF 1-A**.

In the event a previous period of HPE eligibility was given within the last 12 months or for current pregnancy, individual was informed that this assessment will be denied.

HPE Representative's Signature <input type="text"/>	HPE Representative's email <input type="text"/>	HPE Representative's ID <input type="text"/>
HPE Representative's Printed Name <input type="text"/>	HPE Representative's Phone <input type="text"/>	Date <input type="text"/>

## 2.40 Click the Pregnant Woman list item

E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>	
Minor Child's Name		Date of birth	Social Security Number (optional)

**Section B. Screening Questions for HPE Individual**

1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaCHIP?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>
4. Are you pregnant?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?	<b>03/29/2014</b>

**Section C. Category/Income Assessment**

NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
JANE DOE	01/17/1984	111-11-1111	HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	1011.00
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

Based on the above attested information, **JANE DOE** from \_\_\_\_\_ until \_\_\_\_\_ or until a determination is made if a Louisiana individual was assisted in applying for Louisiana HPEQE completed BHS. In the event a previous period of HPE eligibility was given within the last 12 months or for current pregnancy, individual was shown \_\_\_\_\_.

HPE Representative's Signature: \_\_\_\_\_  
HPE Representative's email: \_\_\_\_\_  
HPE Representative's Printed Name: \_\_\_\_\_  
HPE Representative's Phone: \_\_\_\_\_  
Date: \_\_\_\_\_

Select the appropriate HPE Coverage Group from the list

Parents and Caretaker Rel  
**Pregnant Woman**  
Breast or Cervical Cancer

## 2.41 Click the text box

E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>	
Minor Child's Name		Date of birth	Social Security Number (optional)

**Section B. Screening Questions for HPE Individual**

1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>
4. Are you pregnant?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?	<b>03/29/2014</b>

**Section C. Category/Income Assessment**

NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?		INCOME
JANE DOE	01/17/1984	111-11-1111	HPE Individual	<input type="checkbox"/> Y	<input type="checkbox"/> N	1011.00
				<input type="checkbox"/> Y	<input type="checkbox"/> N	
				<input type="checkbox"/> Y	<input type="checkbox"/> N	
				<input type="checkbox"/> Y	<input type="checkbox"/> N	
				<input type="checkbox"/> Y	<input type="checkbox"/> N	
				<input type="checkbox"/> Y	<input type="checkbox"/> N	
Total household income						1011.00

Based on the above information, [Name] is presumptively eligible for **Pregnant Woman**.

from [Name] made if a Louisiana Medicaid application is submitted prior to the end date above.

Individual was a [Name] **ated BHSF 1-A**

In the event a previous [Name] or for current pregnancy, individual was informed that this assessment will be denied.

HPE Representative's Signature	HPE Representative's email	HPE Representative's ID
<input type="text"/>	<input type="text"/>	<input type="text"/>
HPE Representative's Printed Name	HPE Representative's Phone	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>

## 2.42 Type 01/17/2014

E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>			
Minor Child's Name		Date of birth	Social Security Number (optional)		
<b>Section B. Screening Questions for HPE Individual</b>					
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>		
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>		
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>		
4. Are you pregnant?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?	<b>03/29/2014</b>		
<b>Section C. Category/Income Assessment</b>					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
JANE DOE	01/17/1984	111-11-1111	HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	1011.00
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
Total household income					1011.00
Based on the above attested information, <b>JANE DOE</b> is presumptively eligible for <b>Pregnant Woman</b> from <b>1/20/2014</b> until <b>1/20/2014</b> or until a determination is made if a Louisiana Medicaid application is submitted prior to the end date above. Individual was assisted in applying for Louisiana <b>HPEQE completed BHSF 1-A</b> . In the event a previous period of HPE eligibility was given within the last 12 months or for current pregnancy, individual was informed that this assessment will be derived.					
HPE Representative's Signature		HPE Representative's email		HPE Representative's ID	
HPE Representative's Printed Name		HPE Representative's Phone		Date	

## 2.43 Type 02/28/2014

E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>	
Minor Child's Name		Date of birth	Social Security Number (optional)

Section B. Screening Questions for HPE Individual			
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>
4. Are you pregnant?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?	<b>03/29/2014</b>

Section C. Category/Income Assessment					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
JANE DOE	01/17/1984	111-11-1111	HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	1011.00
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
Total household income					1011.00

**JANE DOE** is presumptively eligible for **Pregnant Woman**

from **1/20/2014** or until a determination is made if a Louisiana Medicaid application is submitted prior to the end date above.

Individual was assisted in applying for Louisiana **HPEQE completed BHSF 1-A**

In the event a previous period of HPE eligibility was given within the last 12 months or for current pregnancy, individual was informed that this assessment will be derived.

HPE Representative's Signature	HPE Representative's email	HPE Representative's ID
HPE Representative's Printed Name	HPE Representative's Phone	Date

### 2.44 Click the text box

[illegible]

## 2.45 Click the BHSF Form 1-A provided list item

E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>	
Minor Child's Name		Date of birth	Social Security Number (optional)

Section B. Screening Questions for HPE Individual			
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaCHIP?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>
4. Are you pregnant?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?	<b>03/29/2014</b>

Section C. Category/Income Assessment					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
JANE DOE	01/17/1984	111-11-1111	HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	1011.00
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
Total household income					1011.00

Based on the above attested information, **JANE DOE** is presumptively eligible for **Pregnant Woman** from **1/20/2014** until **02/28/14** or until a determination is made if a Louisiana Medicaid application is submitted prior to the end date above.

Individual was assisted in applying for Louisiana Medicaid. In the event a previous period of HPE eligibility was given, this assessment will be derived.

HPE Representative's Signature: **HPEQE completed BHSF 1-A**  
**BHSF Form 1-A provided**  
 referral to CSU Hotline for phone application  
 referral to LA Medicaid Online Application  
 referral to Application Center

HPE Representative's ID: \_\_\_\_\_  
 HPE Representative's Printed Name: \_\_\_\_\_  
 HPE Representative's Phone: \_\_\_\_\_  
 Date: \_\_\_\_\_

## 2.46 Press Tab

E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>			
Minor Child's Name		Date of birth	Social Security Number (optional)		
<b>Section B. Screening Questions for HPE Individual</b>					
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>		
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaCHIP?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>		
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>		
4. Are you pregnant?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?	<b>03/29/2014</b>		
<b>Section C. Category/Income Assessment</b>					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
JANE DOE	01/17/1984	111-11-1111	HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	1011.00
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
Total household income					1011.00
Based on the above attested information, <b>JANE DOE</b> is presumptively eligible for <b>Pregnant Woman</b> .					
for <b>1/20/2014</b> until <b>02/28/14</b> or until a determination is made if a Louisiana Medicaid application is submitted prior to the end date above.					
Individual was assisted in applying for Louisiana <b>BHSF Form 1-A provided</b> .					
In the event a previous period of HPE eligibility was given within the last 12 months or for current pregnancy, individual was informed that this assessment will be derived.					
HPE Representative's Signature		HPE Representative's email		HPE Representative's ID	
HPE Representative's Printed Name		HPE Representative's Phone		Date	

## 2.47 Type THERESA.CARTER@LA.GOV

E-mail Address JANEDOE@EXAMPLE.COM		Parish of Residence CADD0			
Minor Child's Name		Date of birth	Social Security Number (optional)		
<b>Section B. Screening Questions for HPE Individual</b>					
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>		
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>		
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>		
4. Are you pregnant?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?	03/29/2014		
<b>Section C. Category/Income Assessment</b>					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
JANE DOE	01/17/1984	111-11-1111	HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	1011.00
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
Total household income					1011.00
Based on the above attested information, JANE DOE is presumptively eligible for Pregnant Woman from 1/20/2014 until 02/28/14 or until a determination is made if a Louisiana Medicaid application is submitted prior to the end date above. Individual was assisted in applying for Louisiana BHSF Form 1-A provided. In the event a previous period of HPE eligibility was given within the last 12 months or for current pregnancy, individual was informed that this assessment will be derived.					
HPE Representative's Signature		HPE Representative's email		HPE Representative's ID	
HPE Representative's Printed Name		HPE Representative's Phone		Date	

## 2.48 Type ABC123

E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>			
Minor Child's Name		Date of birth	Social Security Number (optional)		
<b>Section B. Screening Questions for HPE Individual</b>					
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>		
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>		
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>		
4. Are you pregnant?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?	<b>03/29/2014</b>		
<b>Section C. Category/Income Assessment</b>					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
JANE DOE	01/17/1984	111-11-1111	HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	1011.00
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
Total household income					1011.00
Based on the above attested information, <b>JANE DOE</b> is presumptively eligible for <b>Pregnant Woman</b> from <b>1/20/2014</b> until <b>02/28/14</b> or until a determination is made if a Louisiana Medicaid application is submitted prior to the end date above. Individual was assisted in applying for Louisiana <b>BHSF Form 1-A provided</b> . In the event a previous period of HPE eligibility was given within the last 12 months or for current pregnancy, individual was informed that this assessment will be derived.					
HPE Representative's Signature		THERESA.CARTER@LA.GOV		HPE Representative's ID	
		HPE Representative's email			
HPE Representative's Printed Name		HPE Representative's Phone		Date	

## 2.49 Type THERESA CARTER

E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>			
Minor Child's Name		Date of birth	Social Security Number (optional)		
<b>Section B. Screening Questions for HPE Individual</b>					
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>		
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>		
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>		
4. Are you pregnant?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?	<b>03/29/2014</b>		
<b>Section C. Category/Income Assessment</b>					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
JANE DOE	01/17/1984	111-11-1111	HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	1011.00
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
Total household income					1011.00
Based on the above attested information, <b>JANE DOE</b> is presumptively eligible for <b>Pregnant Woman</b> for <b>1/20/2014</b> until <b>02/28/14</b> or until a determination is made if a Louisiana Medicaid application is submitted prior to the end date above. Individual was assisted in applying for Louisiana <b>BHSF Form 1-A provided</b> in the event a previous period of HPE eligibility was given within the last 12 months or for current pregnancy, individual was informed that this assessment will be denied.					
HPE Representative's Signature		THERESA.CARTER@LA.GOV		ABC123	
HPE Representative's Printed Name		HPE Representative's email		HPE Representative's ID	
		HPE Representative's Phone		Date	

## 2.50 Type 318-862-9954

E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>			
Minor Child's Name		Date of birth	Social Security Number (optional)		
<b>Section B. Screening Questions for HPE Individual</b>					
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>		
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>		
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>		
4. Are you pregnant?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?	<b>03/29/2014</b>		
<b>Section C. Category/Income Assessment</b>					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
JANE DOE	01/17/1984	111-11-1111	HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	1011.00
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
Total household income					1011.00
Based on the above attested information, <b>JANE DOE</b> is presumptively eligible for <b>Pregnant Woman</b> from <b>1/20/2014</b> until <b>02/28/14</b> or until a determination is made if a Louisiana Medicaid application is submitted prior to the end date above. Individual was assisted in applying for Louisiana <b>BHSF Form 1-A provided</b> . In the event a previous period of HPE eligibility was given within the last 12 months or for current pregnancy, individual was informed that this assessment will be denied.					
HPE Representative's Signature		HPE Representative's email		HPE Representative's ID	
<b>THERESA CARTER</b>		<b>THERESA.CARTER@LA.GOV</b>		<b>ABC123</b>	
HPE Representative's Printed Name		HPE Representative's Phone		Date	

## 2.51 Type 01/20/2014

E-mail Address <b>JANEDOE@EXAMPLE.COM</b>		Parish of Residence <b>CADDO</b>			
Minor Child's Name		Date of birth	Social Security Number (optional)		
<b>Section B. Screening Questions for HPE Individual</b>					
1. Have you received HPE within the last 12 months? Or for this pregnancy?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>	5. Do you receive Medicare?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>		
2. Are you a US Citizen?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	6. Do you currently receive Medicaid/LaChip?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>		
3. Are you a Louisiana resident?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	7. Were you a foster child at age 18?	<input type="checkbox"/> YN <input checked="" type="checkbox"/>		
4. Are you pregnant?	<input checked="" type="checkbox"/> YN <input type="checkbox"/>	8. What is your expected delivery date?	<b>03/29/2014</b>		
<b>Section C. Category/Income Assessment</b>					
NAME	DOB	SSN (Optional)	RELATIONSHIP	IS THIS A CHILD IN YOUR CARE?	INCOME
JANE DOE	01/17/1984	111-11-1111	HPE Individual	<input type="checkbox"/> Y <input type="checkbox"/> N	1011.00
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
Total household income					1011.00
Based on the above attested information, <b>JANE DOE</b> is presumptively eligible for <b>Pregnant Woman</b> from <b>1/20/2014</b> until <b>02/28/14</b> or until a determination is made if a Louisiana Medicaid application is submitted prior to the end date above. Individual was assisted in applying for Louisiana <b>BHSF Form 1-A provided</b> . In the event a previous period of HPE eligibility was given within the last 12 months or for current pregnancy, individual was informed that this assessment will be denied.					
HPE Representative's Signature		HPE Representative's email		HPE Representative's ID	
<b>THERESA CARTER</b>		<b>THERESA.CARTER@LA.GOV</b>		<b>ABC123</b>	
HPE Representative's Printed Name		HPE Representative's Phone		Date	
		<b>318-862-9954</b>			